MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH DEPARTMENT OF PUBLIC HEALTH AND WELFARE. 3007

-63-905474

		Vr r		C HEALTH AND WE	IL FARE		300	7	. ,	STATE FILE NU	<u> </u>
	AMEN	DED		Registration District No	Prin	nary Registration D	istrict No.	Registrer's No.	13.68	E. SANT FILE ME	
	<u> </u>	 1	-[-	PLACE OF BEATH a. COUNTY BU	MAR 7 1963 itler	· ,		2. USUAL RESIDEN a. STATE MIS	CE (Where decease SOUTE COUNT	d lived. If Institution: TY Butler	Residence before admission)
WEND						SHIP only)	ength of stay in 1b Years	c. CITY OR PO	plar Blu	ff	Inside Limits Yes 🖰 No 🗌
				UACDITAL AD		•	Inside Limits Yes ∑ No □	d. STREET ADDRESS			Reside on Ferm
12	$\dagger \dagger$	$\dagger \dagger$]=	3. NAME OF DECEASED (Type or print)	First JOSEPH			Lest PHERSON	4. DATE OF DEATH	Month Day February 1	9, 1963
			1	Male	6. COLOR OR RACE White	Widowed 🗖	Divorced 1	8. DATE OF BIRTH 5/13/08	9. AGE (last birth	Months Days	Hours Min.
SWS				during most of working	(Give kind of work done g life, even if retired)	Sawmi	ill	Newark, A	rkansas.	U. S.	Α.
<u> </u>				Joseph	McPherson		Unknow	m		ivorced.	
R. AS			,	Yes, no, or unknown) (If	yes, give war or dates of	servi	IAL SECURITY NO.	Mrs. Nol	an Taylo	r, Batesvi	lle, Ark
₽ A A				18. CAUSE OF DEATH PART I.	DEATH WAS CAUSED BY	4.4.	mably of	natural	rouses		TERVAL BETWEEN NSEPAND DEATH
		\frac{1}{2}	}	Condition		" /a.	fension a	sthustic	; at VA	HAM.	<u> </u>
THIS				above c	cause (a), }	(0)	0 -0 14	۱ نه ۱	·		
ایس	\sqcap	+-		lying ca	ause last. J DUE TO (d		in istuff	1960 au	agam 196	1	
ST ON	\prod		ATION	lying ca			RIBUTING TO DEAT	H but not related to	agam /96		was female was sucy in last 90 days.
		+-	CERTIFICATION	lying ca	ause last. J DUE TO (d	ONDITIONS CONT				there a pregna	No Unknown
AMENDMENTS ON				PART II. 19. WAS AUTOPSY PERFORMED?	ause last.] DUE TO (c OTHER SIGNIFICANT C disease condition given I 20a. ACCIDENT SUICID Month, Day, Year	CONDITIONS CONT IN PART I (a) DE HOMICIDE	206. DESCRIBE HOV	W INJURY OCCURRED.	. (Enter nature of inj	there a pregna	No Unknown of item 18.)
AMENDMENTS		+-	CAL CERTIF	19. WAS AUTOPSY PERFORMED? YES NO 20. TIME OF Hour INJURY s.m.	20a. ACCIDENT SUICID Month, Day, Year 20b. PLACE form, 1	ONDITIONS CONT	206. DESCRIBE HOV	W INJURY OCCURRED.	LOCATION	there a pregne	No Unknown
AMENDMENTS			CAL CERTIF	19. WAS AUTOPSY PERFORMED? YES NO 20. TIME OF Hour INJURY 8.m. p.m. 20d. INJURY OCCURRE WHILE AT WORK	AUSTRICT SUICIDENT SUICIDE	CONDITIONS CONT IN PART I (a) DE HOMICIDE	in or about home, ce bldg., etc.)	W INJURY OCCURRED. 20f. CITY, TOWN, OR	c. (Enter nature of inj	there a pregne	No Unknown of item 18.)
			OF MEDICAL CENTIFI	Iying ca PART II. 19. WAS AUTOPSY PERFORMED? YES NO 20c. TIME OF Hour INJURY OCCURRE WHILE AT WORK NOT WHILE AT W 21. I attended the dec Death occurred at	AVANCE DUE TO (continue to the continue to th	OF INJURY (e.g., factory, street, office	in or about home, 2 ce bldg., etc.)	20f. City, Town, Or end are date stated above, as 22b. ADDRESS Poplar B	LOCATION d last saw her alive and to the best of m	COUNTY con	No Unknown of item 18.)
AMENDMENTS		A CELLA VIT OF	HIDAVII OF MEDICAL CERTIFI	Iying ca PART II. 19. WAS AUTOPSY PERFORMED? YES NO 20c. TIME OF Hour INJURY B.m. 20d. INJURY OCCURRE WHILE AT WORK NOT WHILE AT W 21. I attended the dec Death Securred at	Month, Day, Year ED WORK ceased from 235. DATE 279/63	DE HOMICIDE OF INJURY (e.g., factory, street, office or title) 23c. NAME C	in or ebout home, 2 ce bldg., etc.) The property of the control o	20f. City, Town, Or end are date stated above, as 22b. ADDRESS Poplar B	t LOCATION d last saw her slive and to the best of m Bluff, Mc 23d. LOCATION (Circ.) Batesvi	COUNTY con	state 22c. PATE SIGNED PLAZ PL
4 4 6 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	STEAD OF DATE AMENDED	STEAD OF DATE AMENDED	STEAD OF DATE OF TOTAL DATE DOCIMENT	STEAD OF DATE AMENDED DATE AMENDED DATE AMENDED DATE AMENDED	PLACE OF BEATH a. COUNTY BU b. CITY (If outside cor OR TOWN POP) c. FULL NAME OF DECEASED (Type or print) 5. SEX Male 10a. USUAL OCCUPATION during ment of workin Labor Over 13a. FATHER'S NAME Joseph 15. WAS DECEASED EVER (Yes, no, ocunknown) (Iff Les. 18. CAUSE OF DEATH PART I.	I. PLACE OF BEATH I. PLACE OF BEATH I. PLACE OF BEATH I. PLACE OF BEATH II. PLACE OF BEATH III. CAUSE OF DEATH III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: III. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY	AMENDED 1. PLACE OF DEATH D MAR 7 1963 a. COUNTY BUTLET b. CITY (If outside corporate limits, give TOWNSHIP only) OR POPLAR BLUFF c. FULL NAME OF (IF NOT in hospitel, give location) HOSPITAL OR 328 N. Riverview 3. NAME OF DECEASED INSTITUTION 328 N. Riverview 3. NAME OF DECEASED INSTITUTION 328 N. Riverview 3. NAME OF DECEASED INSTITUTION 328 N. Riverview 4. JOSEPH YOUN 5. SEX A. COLOR OR RACE Widowed 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawmi 13b. MOTH 13b. MOTH 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give, war or dates of serving the same of the s	AMENDED Registration District No. Place of Death DMAR 7 1963 a. COUNTY Butler b. CITY (if outside corporate limits, give TOWNSHIP only) C. FULL NAME OF (if NOT in hospital, give location) Inside Limits HOSPITAL OR 328 N. Riverview 3. NAME OF DECEASED First Middle (Type or print) S. SEX JOSEPH Middle White Widowad Never Married Divorced White Widowad Never Married Divorced Divorced Sawmill 13a. FATHER'S NAME JOSEPH MC Pherson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes, give, were of lates of services, no, or unknown) (if yes, give, were of lates of yes, no, or unknown) (if yes, give, were of lates of yes, no,	Registretion District No. Primary Registretion District No. Registret's No. No.	Registration District No. Primary Registration District No. Registrat's No. 22. USUAL RESIDENCE (Where decease a state Missour's county Butler 1. Place of Bertiff D MAR 7 1968 2. USUAL RESIDENCE (Where decease a state Missour's county Butler b. CITY (If outside corporate limits, give FOWNSHIP only) Length of stey in 1b C. CITY OWN Poplar Blue C. FULL NAME OF (If NOT in hospitel, give location) Inside Limits d. STREET (If outside Limits HOSPITAL OR 328 N. Riverview Yes & No. 28 N.	AMENDED Registral No

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STATEMENT BY LICENSED EMBALMEN

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vorking under	r my personal supe	ervision. · · ·		: -		Pacific Soll
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	Signature of Stud	dent Embalmer			. //	
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		_				P. O. Address Reconstitution

with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.